Bruce Nelson DDS
LASER & MICROSCOPE ENHANCED DENTISTRY

Patient Information
(please fill out completely)

Patient
Last Name _____ First_____ You prefer to be called _____ Middle _____
Address_____ City _____ State _____ Zip _____
How long at this address? _____ Date of Birth _____Home Phone _____
Minor ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated ____
Social Security # _____ Drivers Lic. # _____
How many children do you have? _____ Do you wish them to become patients? _____
Patient's Employer _____ How long employed? _____
Position _____ Business Phone _____
Employers Address _____ City _____ State _____ Zip _____
Email Address _____ Cell # _____

Spouse
Name _____ Social Security # _____ Date of Birth _____
Employer _____ Address _____
Position _____ Business Phone _____

Person Responsible for Account (if different from above)
Name _____ Social Security # _____ Drivers Lic. # _____
Address _____ City _____ State _____ Zip _____
Employer _____ Address _____
Business Phone _____ Relationship to Patient _____
How long employed _____ Date of Birth _____
In case of emergency name _____ Address _____ Phone _____

Dental Insurance
Ins. Name & Address _____ Policy # / Soc. Sec. # _____
Ins. Name & Address _____Policy # / Soc. Sec. # _____

Whom May We Thank for Referring You to Our Office? _____
Please list any other family members seen by Dr. Nelson _____

Dental History
How can we help you? _____
If you could, would you change anything about your teeth? _____
Last Dental Visit _____ Purpose _____ Last Complete Exam _____
Has fear of discomfort kept you from regular visits? _____
How would you describe your present dental health? _____
Do your gums ever bleed? Y _____ N _____ Are you troubled with bad breath? Y _____ N _____
Home Care: Brush? Y _____ N _____ Floss? Y _____ N _____ Water Jet? Y _____ N _____
Have you had any unusual effects from previous dental treatments? Y _____ N _____
Please describe: _____
Does your jaw click or hurt? Y _____ N _____ Are you bothered by headaches? Y_____ N_____

Patient Information Continued
(please fill out completely)

Medical History

Medical Dr.'s Name _____ Address _____
Date of last physical _____ Are you under a doctor's care now? Y _____ N _____
If so, why? _____
Have you been hospitalized in the last two years? Y _____ N _____ Why? _____
Do you have any serious illness? Y _____ N _____ What? _____
Pharmacy Name _____ Pharmacy Phone #_____ Pharmacy Address _____

Have you ever had any of the following?

_____ Heart Murmur	_____ Arthritis	_____ Diabetes
_____ Rheumatic Fever	_____ Asthma	_____ Tuberculosis
_____ Heart Trouble	_____ Psychiatric Treatment	_____ Epilepsy
_____ High Blood Pressure	_____ Jaundice	_____ Stroke
_____ Prolonged Bleeding	_____ Venereal Disease	_____ Hepatitis
_____ Herpes	_____ Pace Maker	_____ AIDS
_____ Thrush (Oral Candida)	_____ Heart Prosthesis	_____ Joint Prosthesis
_____ Latex Allergy	_____ Nickel Allergy	_____ Sulfites
_____ Recreational Drugs	_____ Medical Marijuana	_____ Tobacco Products / Vaping

HAVE YOU BEEN EXPOSED TO HEPATITIS? Y ___ N ___ When: _____
HAVE YOU BEEN EXPOSED TO AIDS/HIV? Y ___ N ___ When: _____
Are you currently taking any drugs or medications: Y ___ N ___ What? _____
_____
List all drug allergies: _____
Any prior or current drug or alcohol abuse problems _____
Do you prefer nitrous oxide analgesia during treatment? Y _____ N _____
WOMEN: Are you pregnant? Y _____ N _____ How long: _____

PLEASE READ CAREFULLY BEFORE SIGNING!

I hearby authorize dental treatment and the use of local anesthetic, nitrous oxide analgesia, or any other medication necessary for dental treatment.

The patient (guardian) agrees to be and hereby is fully responsible for total payment of procedures performed in this office including any amounts which are not covered by any dental insurance that the patient may have. I further approve the release of information to my insurance company necessary to process claims.

Account balances remaining due after the last day of the month following billing will bear interest at a rate of 1.5% per month on the declining balance (18% APR).

The undersigned further agrees to pay actual attorney's fees incurred in the collection of this account, whether or not suit is filed. In the event of a default judgement, attorney's fees of not less than 25% of the principal balance shall be added.

Signature _____ Date _____